



Anita B. Wright  
Counseling, Tea and Therapy  
P L L C

# CREDIT CARD AUTHORIZATION FORM

Please complete all fields below. You may cancel this authorization at any time by contacting me or my staff. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover	<input type="checkbox"/> AMEX <input type="checkbox"/> Other
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):				
Cardholder ZIP Code (from credit card billing address):				

I, \_\_\_\_\_, authorize \_\_\_\_\_ to charge my credit card above for agreed upon purchases or therapeutic sessions via Face-to-Face or Telemental Health. I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date



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